



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXOMA MEDICAL CENTER
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name

Hartford Underwriters Insurance

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-4820-01

MFDR Date Received

August 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility \$1,180.40 for the MAR at 200%. Based on their payment of \$1,127.93, a supplemental payment of \$67.36 is due."

Amount in Dispute: \$67.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Paid per MF6 calculations correct based on Denison, TX zip code 75020."

Response Submitted by: The Hartford, 300 S. State St, Syracuse, NY 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2011	Outpatient Hospital Services	\$67.36	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 16, 2011

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT PAYMENT OF SERVICES ARE INCLUDED IN THE VISIT RATE.
- 97 – PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX INCLUDED IN GLOBAL REIMBURSEMENT. REIMBURSEMENT IS BEING WITHHELD AS THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROC BILLED.
- 217 – THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY ZMETRIX'S BILLCHK SERVICE
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT THIS SERVICE IS RE-PRICED ACCORDING TO THE TX PHYSICIAN FEE SCHEDULE

EXPLANATION OF BENEFITS DATED JULY 21, 2011

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. REIMBURSEMENT FOR YOUR NO ADDITIONAL MONIES BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO STATE FEE GUIDELINES OR RULES AND REGULATIONS.
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. REIMBURSEMENT BASED ON QMETRIX CORRECTION.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement." Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no

separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
- Procedure code 80048 is unbundled. This procedure is a component service of procedure code 80053 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. 125% of this amount is \$18.59. The recommended payment is \$18.59.
- Procedure code 82553 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.66. 125% of this amount is \$10.83. The recommended payment is \$10.83.
- Procedure code 83874 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$18.17. 125% of this amount is \$22.71. The recommended payment is \$22.71.
- Procedure code 83880 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$47.77. 125% of this amount is \$59.71. The recommended payment is \$59.71.
- Procedure code 84484 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.85. 125% of this amount is \$17.31. The recommended payment is \$17.31.
- Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.11. 125% of this amount is \$11.39. The recommended payment is \$11.39.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.53. 125% of this amount is \$6.91. The recommended payment is \$6.91.

- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.45. 125% of this amount is \$10.56. The recommended payment is \$10.56.
 - Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this ancillary procedure code is packaged when reported on the same claim as the critical care evaluation and management code 99291; however, this service does not meet the criteria for critical care packaging. This line is not assigned to a composite APC and may be paid separately. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.
 - Procedure code 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If OPPS criteria are met, this service is assigned to composite APC 8005. Review of the submitted information finds that the criteria for composite payment have not been met. Separate payment is allowed. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0332, which, per OPPS Addendum A, has a payment rate of \$193.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$116.31. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$111.20. The non-labor related portion is 40% of the APC rate or \$77.54. The sum of the labor and non-labor related amounts is \$188.74. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this line is \$188.74. This amount multiplied by 200% yields a MAR of \$377.48.
 - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If OPPS criteria are met, this service is assigned to composite APC 8003. Review of the submitted information finds that the criteria for composite payment have not been met. Separate payment is allowed. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$127.69. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$216.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this line is \$216.72. This amount multiplied by 200% yields a MAR of \$433.44.
 - Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.36. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$15.64. The non-labor related portion is 40% of the APC rate or \$10.90. The sum of the labor and non-labor related amounts is \$26.54. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this line is \$26.54. This amount multiplied by 200% yields a MAR of \$53.08.
4. The total allowable reimbursement for the services in dispute is \$1,113.46. This amount less the amount previously paid by the insurance carrier of \$1,127.93 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____ April 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.